PHARMACY ADJUSTMENT REQUEST

MAIL TO :
EDS CORPORATION
POST OFFICE BOX 300009
RALEIGH, NORTH CAROLINA 27622

ATTN: ADJUSTMENT UNIT

RECIPIENT MEDICAID NUMBER

PHARMACY NAME AND PROVIDER NUMBER

RECIPIENT NAME
LAST FIRST MIDDLE

PLEASE PRINT OR TYPE (BLACK OR DARK BLUE ONLY) **LIST INFORMATION AS GIVEN ON RA**

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Rx NUMBER	DRUG NAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT

DATE FILLED MO DAY YR	CLAIM NUMBER	DENIAL EOB	INS PAID

ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) | PAID AMOUNT

1

Rx NUMBER	DRUG NAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT

DATE FILLED MO DAY YR	CLAIM NUMBER	DENIAL EOB	INS PAID

ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) | PAID AMOUNT

2

Rx NUMBER	DRUG NAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT

DATE FILLED MO DAY YR	CLAIM NUMBER	DENIAL EOB	INS PAID

ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) | PAID AMOUNT

3

Rx NUMBER	DRUG NAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT

DATE FILLED MO DAY YR	CLAIM NUMBER	DENIAL EOB	INS PAID

ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) | PAID AMOUNT

"This is to certify that the foregoing information is true, accurate, and complete. I understand that payment will be from Federal and State funds, and that any false claims, statements, or documents, or concealment, of a material fact, may be prosecuted under applicable Federal or State laws."

X_____
CLAIMANT SIGNATURE DATE

IMPORTANT: THIS FORM WILL BE RETURNED IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING IS NOT PRESENT.

FORM NO. 372-200 (REVISED 5-2000)